

**Before the  
Federal Communications Commission  
Washington, D.C. 20554**

In the Matter of:

Notice of Proposed Rulemaking (NPRM)	)	WC Docket No. 02-60
Regarding the Universal Service Support	)	
Mechanism For Rural Health Care	)	

**Comments of the Internet2 Ad Hoc Health Group**

## Table of Contents

### I. Introduction

Summary.....	4
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### II. Health Infrastructure Program

9. Initial Application Phase (Program process) .....	5
10. Project Selection Phase.....	7
14. Connectivity speed .....	7
15. Demonstrated Needs Criteria .....	8
16. Demonstrating need for infrastructure funding.....	8
17. Justifying funding based on a financial analysis .....	9
20. Letters of Agency.....	10
24. Cap on Amount Funded per Project.....	11
25. Cap on Number of Projects per Year .....	11
30. Network Design .....	11
32. Limitation on Administrative Expense.....	12
33. Maintenance Costs.....	12
34. Internet2 and NLR .....	12
36. Ineligible costs .....	13
38. Minimum Participant Contribution.....	14
40. Evidence of Viable Source for 15 Percent Contribution .....	15
41. Eligible Sources .....	15
42. Project Milestones .....	15
45. Network Coverage .....	15
47. Health IT Purposes.....	15
48. Emergency Response Connectivity .....	16
49. Facilities ownership, IRU or Capital Lease Requirements.....	16
59. Sustainability Reporting Requirement .....	16
61. Shared Use.....	16

**III. Health Broadband Services Program**

**84. Health Broadband Services Program..... 17**

**87. Eligible Access and Transport Services..... 17**

**90. Access to advanced telecommunications and information services..... 17**

**91. Minimum Level of Broadband Capability ..... 18**

**97. Restrictions on Satellite Services ..... 19**

**100. Level of Support..... 19**

**105.-106. Multi Year Contracts..... 20**

**107. Opting into the Health Broadband Services Program..... 20**

**108. – 111. Administrative Offices ..... 20**

**114. Data Centers ..... 21**

**117. Skilled Nursing Facilities ..... 22**

**121. Annual Caps and Prioritization Rules ..... 22**

**122. Prioritization Rules ..... 23**

**134. Meaningful Use Criteria ..... 23**

**139. Health Care Broadband Status Report and Testing Mechanisms ..... 23**

**141. Creating a workgroup to develop recommendations ..... 24**

**Addendum 1..... 25**

**Addendum 2..... 28**

**Addendum 3..... 29**

## I. Introduction

### Summary

We commend the Commission for its revisions to the Rural Health Program. The rules proposed by the NPRM should significantly advance the goals of the Rural Health Program. The Commission should continue to closely monitor and evaluate the effect of these changes as they are implemented.

The revised Rural Health Program should ensure that the consortia organizations that were created as part of the Rural Health Care Pilot Program are enabled to effectively participate in the revised program without impediments. We applaud the expansion of supported facilities to include data centers and administrative offices. We also support the idea of forming a workgroup to provide the Commission with recommendations for the Rural Health Care Support Mechanism.

The Commission should provide USAC with the direction and resources necessary to carry out its additional responsibilities in the revised program. It should also direct USAC to make all decisions regarding compliance in a timely manner and in writing. We have recommended a number of changes to USAC processes, and we encourage the Commission to direct USAC to improve their forms, decision-making processes, and information management systems.

In the eRate program, USAC is required to report their estimates of the unused funds and the Commission can direct USAC to rollover funds to increase the overall funding pot.<sup>1</sup> We recommend that the Commission use this process for the Rural Health Program as well as the eRate program.

We understand that the Commission cannot support facilities for custodial or nursing care due to its limited legislative mandate. However, these institutions play a critical role in health care delivery, and we will work to include these institutions, especially ones that are non-profit, in the Commission's programs.

For there to be a truly effective health care environment in the US all health care providers should be connected into a Nationwide Health Network. This includes both rural and urban areas. Anything less results in a network that is suboptimal in its support for health information exchange. We recognize that it would require a legislative change to include for-profit providers, but the Commission is encouraged to keep this goal in mind. Where possible, providers should be incentivized to interconnect networks, including networks built with funding from HHS/ONC initiatives like the Statewide HIE Cooperative Agreement Program.

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<sup>1</sup> 47 C.F.R. § 54.507(a)(2).

## II. Health Infrastructure Program

### 9. Initial Application Phase (Program process)

Comment: One of the administrative problems with the Rural Health Care Pilot Program (RHCPP) was the use of the primary program's forms and portions of its administrative process. Participants appreciated the more interactive approach to the Pilot Program compared to the primary program's reliance on a complex electronic application process that is designed for single site Health Care Providers. While the attempt at personal interaction with coaches, senior management at USAC and the FCC was well intentioned, decision-making was delayed and communication issues resulted from novel issues. This should not be allowed in the revised program.

We would like the Commission to consider revising the personal interactive portion of the administrative process but only if it can be made efficient and effective. To make the process more efficient, program managers should be resident at the USAC offices to ensure effective and efficient communication. They should be experts with respect to all rules and regulations and empowered to make decisions without seeking senior management's input or that of the Commission. Due to the nature of the Health Infrastructure Program (HIP) and the deadlines for each phase of the administrative process, interaction with potential and selected participants will require program managers to be experienced in federal grant/project management, health care and current telecommunications technology and their implementation strategies.

The forms used by USAC to administer the program need to be revised to meet the new programs goals and ensure efficiency and completeness. A new Consortium Form should replace the existing Form 465 and an electronic equivalent should be created. New certifications should be created that are more applicable to the HIP. For example, current forms do not take into account urban Health Care Providers, which can make the collection of LOA's problematic. Signatories to LOA's and the revised Form 465 will regard the signing of current certifications, especially those confirming rural location and for-profit status, as misleading, even if the new HIP allows these entities to participate in proposed networks. Also, health care may not be provided at an Administrative office or Data Center, but ownership may be of a greater consideration.

All data requirements should be known in advance of the Initial application phase. Subjective requirements such as the twelve that are mentioned in the Project commitment phase (paragraph 11 of the NPRM) should be explained in detail and examples should be created by USAC. USAC should conduct an extensive outreach campaign and create a robust and informative website where these documents and examples are available to the public. Entity eligibility definitions and examples of each designation should also be posted on USAC's website for at least 3 months prior the start of a funding year. We strongly recommend that USAC be required to engage with potential HIP applicants to determine the

eligibility of all sites in their proposed networks. USAC should provide data on all current known eligible entities. All submissions should be able to be completed offline as well as online.

When dealing with large consortia, it may be necessary to share application information with other members. USAC should be given the data collection requirements in advance of creating the administrative process for the HIP and the Network Cost Worksheet (NCW) and Form 466-A attachment should be discarded in favor of a more cohesive funding application.

The Quarterly report should be electronic and required only after a commitment has been issued.

In addition we recommend:

- a. The Commission should commit resources to a process improvement project designed to improve the efficiency of USAC administrative processes. USAC should retain all documents in electronic format for later retrieval and adopt a document management system capable of reducing the administrative burden on all parties – THE COMMISSION, USAC staff, and provider recipients. Organizations will change and staff will have turnover perhaps several times during this period. When data have already been submitted, USAC should not make repeated requests for it, adding more of an administrative burden to the recipient.
- b. Portions of the quarterly reports may contain confidential or proprietary information that should not be made publically available until after vendors are selected and commitments issued.
- c. A waiver process and expedited appeals process should be implemented. Projects in the proposed HIP have a period of three funding years (commencing with the funding year in which the initial online application was submitted) to file all forms and supporting documents necessary to receive funding commitment letters from USAC. A project could be seriously delayed and unable to be completed unless USAC can administratively waive a project's three-year deadline or expedite a waiver or appeal in a timely fashion.
- d. Lack of an "eligible services and equipment matrix" ensures that emerging technologies and network configurations will face administrative roadblocks as their eligibility is challenged. Decisions on appealed matters should be made publically available.
- e. The invoicing process should change if recurring charges are eligible in the HIP. If recurring charges are not eligible, more detail should be provided about whatever forms replace the Network Cost Worksheet (NCW) and Form 466-A attachment.
- f. Currently commitments are made to an award recipient for a specific site with the resources concretely specified. Commitments should be made to the award recipient on a category basis such as construction costs or maintenance rather than a line item basis. Eligible expenses should be billed against that line item.

- If costs go up or down it would not be an issue to USAC/THE COMMISSION.
- g. Given that some USF-supported projects can take years from inception to implementation, HCPs occasionally want to add new sites (not originally listed on the Form 465 Attachment). Assuming a project has sufficient funding, it should be permitted to add some de minimis number of sites (e.g., 5% to 10% of the original total) without having to re-post the RFP and bid out the new sites. Modifications to networks and commitments should be made easier. For example, competitive bidding may make equipment purchases cheaper, and projects should be able to easily reprogram these funds.
  - h. Three-year clock should start from the date of the initial commitment. The proposed HIP would be a disadvantage to projects that have to wait for USAC to make a commitment or are delayed while appeals or waivers are being considered. Even given the best of circumstances a project might not receive a commitment until the first funding year is over.

## 10. Project Selection Phase

Comment: All selections and denials should be made in writing. If a project is denied funding, specific reasons should be stated in the written denial. A stringent but effective denial appeals process should be established.

## 14. Connectivity speed

- The NPRM proposes setting 10 Mbps as the minimum broadband speed for infrastructure deployment.

Comment: Health Care Broadband in America does an excellent job of analyzing today's broadband requirements for Health Care.<sup>2</sup> This is a particularly difficult topic to address completely. We recognize that there are many sites that can only be reached at lower speeds, especially those linked by wireless. Failure to include them in the Rural Health Program will exacerbate the digital divide that can result in further variations in the availability and quality of health care.

At the same time while speeds of 10Mbps may be acceptable today they will not be over the 10-20 year lifespan of the network. In fact, network speeds of 100Mbps or even 1Gbps or higher are becoming the norm in many areas even today. Technology costs for achieving these speeds are declining and the Rural Health Program should encourage this evolution.

For example, in Florida members of the statewide health information exchange program have decided that 10Mbps is a relatively low speed for full-blown health information exchange. It supports transfer of text files but does not lend itself to

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<sup>2</sup> Health care Broadband in America: Early analysis and a path forward, Heath IT Use Cases and Associated Actual Broadband Requirements, p.6, FCC OBI Technical Paper No. 5, August 2010

efficient transfer of digital image files such as x-rays or MRIs. 10Mbps can be set as a *minimum* but this should be a starting point with expectations that the speed will and should increase over time.

We encourage the Commission to not equate the lowest cost with health care effectiveness in all instances. Efficient and effective delivery of health care should be the goal of the Rural Health Program. Health care availability and quality in the U.S. varies significantly often because it is accessible in some regions and not accessible in others. The bandwidth standards for the program need to include the flexibility to support current underserved areas while increasing future minimum requirements.

Recommendation 14.1: Projects may include sites that simply cannot deploy infrastructure that supports 10 mbps due to geography, technical, or affordability considerations. Allowance for such sites should be made so they are not excluded solely for failure to meet the minimum bandwidth requirement.

Recommendation 14.2: Every project proposal should compare the costs of at least two or three broadband speeds to select the most appropriate option for today and the life of the project with cost being one, but not the only, factor. Broadband speeds should be allowed to vary inside a single project. Large projects may face diverse requirements that require varying capacities in their network infrastructure.

## **15. Demonstrated Needs Criteria**

Comment: By definition this program is focused on rural area broadband. However the National Broadband Plan also addressed urban providers with few resources to obtain access to broadband. These providers could include free clinics or providers serving areas of urban blight. From the perspective of health information exchange, providing connectivity to providers in urban locations is just as vital as serving rural providers.

## **16. Demonstrating need for infrastructure funding**

Use any of the following methods to verify no or insufficient broadband:

- Provide a survey by a qualified expert of current carrier capabilities plus a report detailing no or inadequate broadband infrastructure
- Provide a copy or link to a recognized mapping study
- Certify that for at least 6 continuous months health care providers did not receive any proposals from qualified vendors

Comment: The proposed rule appears to assume a model where a single health care provider wants to build or acquire a point-to-point connection. Consortia of health care providers can reduce their costs and address the problem of 'silos' or 'islands' of health care by creating IP based health networks. This rule may discourage their development.

It is important that this program not only consider building infrastructure where necessary but also encourage the leveraging of existing capacity that is unused. For example, in rural Florida there is dark fiber that could be used to connect rural hospitals and other providers. Again, access is not related to “availability” as much as “affordability,” but availability is overlooked as a criterion. Using “availability” as the only criterion for an award would disqualify most of Florida’s rural hospitals who are facing a construction push following the Broadband Telecommunication Opportunity Program, which will make broadband services more available, but not necessarily more affordable.

The proposed survey is unrealistic for an individual provider because of the expense involved in hiring a qualified individual, gathering the requisite data and developing the report. Sharing the burden across a consortium of health care institutions may reduce that burden some, but possibly not enough.

Verification of no or insufficient bandwidth for a period of six months likewise places a significant burden on the health care provider. The fact that adequate broadband speeds have been advertized does mean that they are actually available, as a recent article notes. (FCC: Broadband Users Are Getting Half of What They Expect By: Chloe Albanesius, PCMAG.com, 08.18.2010) It is also quite possible that proposals would be unaffordable. An unaffordable service is the same as NO SERVICE for the health care provider and should be taken into account.

Recommendation 16.1: We believe that current processes for public notification of forms and RFPs used by USAC are sufficient and should continue to be used for validating the proposed sites for a project. That is, a consortium will use its best available resources and judgment to identify and propose the relevant sites for a project.

## **17. Justifying funding based on a financial analysis**

- Provide a financial analysis that shows the cost of the new facilities is significantly less expensive over a specified period (15-20 years)

Comment: It may be unreasonable for the health care providers to bear the cost of a financial analysis. Also, it may not be feasible because the costs are often unknowable until the planning and design are complete. However, if the health care provider opts to develop this analysis then the following recommendation holds.

Recommendation 17.1: The financial analysis should be the sole criterion for the construction of the network. This should be based on the data and costs from the planning phase and show a savings of at least 5% for the health care provider over a period of 10, 15 or 20 years. The Commission should develop a very simple financial analysis form and allow its use.

## 20. Letters of Agency

The NPRM proposes that applicants must provide:

- A list of all eligible providers seeking the funding
- The lead organization (responsible for the application)
- Letters of Agency from each participating organization

Comment: Letters of Agency should be adapted to the realities of the rural health care environment of this program. Participants often cannot know what they are committing to because the costs are unknown. This is the usual case when the planning and network design have not been completed and the network participants are still being recruited. Letters of Agency therefore should be reasonable and provide the Commission with a much more accurate picture of the interest and ability of the network to sustain itself. We note that the North Carolina Telehealth Network has adapted an appropriate Letter of Agency for this program. (Addendum 1) We encourage the Commission to adopt this when Letters of Agency are required.

Identifying ALL network participants in a region is problematic – health care organizations adapt to the needs of the community and may move between locations for a variety of reasons. For example, Community Clinics may take available space in a shopping center and move and or change their name within a year or two due to economics or population shifts. Health care organizations are dynamic with new organizations arising to meet specific needs such as specialty care clinics and outpatient facilities.

The Commission should allow flexibility to account for an environment in which new diseases, new treatments, new clinical approaches, and new technologies make health care a dynamic and evolving enterprise. Locating and listing all network participants as a prelude to project proposal is not always practical.

Recommendation 20.1: Allow proposals that document target areas with statistics about the eligible providers (e.g. over 300 eligible provider sites are within a mile of the fiber route that this project proposes).

Recommendation 20.2: Allow applicants to identify as many of the health care organizations as possible that are likely to participate in a health network, but allow for fluctuation among the participants as providers move into or out of an area. The Commission/USAC should facilitate a dynamic and evolving infrastructure through a process that complements and/or becomes a part of the Letter of Agency process.

Recommendation 20.3: The Commission should establish a workable process to identify changes in network participation. A process such as an online Notice of Participant Change should be adopted. See our comments above in #9-g.

Recommendation 20.4: The Commission should provide a sample Letter of Agency like the one created by the North Carolina Telehealth Network to serve as a pre-approved form for circumstances where a LOA is required.

## **24. Cap on Amount Funded per Project**

- The Commission seeks comment on whether \$15 million, or some other figure, is the correct per project cap to use.
- The Commission notes that it would retain authority to consider an applicant's request for waiver of the per project cap on a case-by-case basis

Comment: It is clear from at least the data from the Rural Health Care Pilot Program that most projects will be less than \$15M. Yet, it is important to recognize that the cost of a project is highly variable and a project that is difficult and costly may be among the most valuable. It is inappropriate to exclude a project (or require a waiver) just because it is costly.

Recommendation 24.1: Do not impose a cap on the per project cost.

## **25. Cap on Number of Projects per Year**

- The Commission seeks comment on whether or not it should place a cap on the number of projects per year.
- USAC could devote more time to a specific project if there are fewer projects that require attention.

Comment: We believe that a better way for USAC to manage its resources would be to reduce the administrative overhead built into the current application process. Worthwhile projects will help meet the health care needs of the nation and deserve to be funded, even if that might require additional resources at USAC.

Recommendation 25.1: Do not impose a limit on the number of projects per year.

## **30. Network Design**

- The Commission proposes a limit of \$1 million per project or 15%, whichever is less.

Comment: It is clear from at least the data from the Rural Health Care Pilot Program that most projects will be less than \$15M and thus a \$1M cap for design may be reasonable. Yet, the cost of a project is highly variable and a difficult and costly project requiring extensive network design may be among the most valuable. It is inappropriate to rule out a project just because it, and the network design of the project, is costly.

Recommendation 30.1: Do not impose a cap on the Network design cost.

### **32. Limitation on Administrative Expense**

The Commission proposes the following limits on administrative expenses:

- 36 months from the notification of eligibility for funding.
- \$100,000 in any one year.
- 10% of the total project cost.

Comment: We applaud the Commission for recognizing the importance of providing administrative support to help ensure successful projects. Project management is recognized as a critical factor in the success of any IT project and is often targeted at 15 to 30% of the overall cost of a project.

The three-year limit seems reasonable. A cap of \$100,000 seems arbitrary and appears to favor smaller projects where the support represents a larger portion of the overall budget. A cap on administrative expenses based on a percentage of the total project cost would treat participants more equally.

Health care providers and consortia staff members may not have project management skills. The language in the proposed rule appears to limit these expenditures to employees.

Recommendation 32.1: Remove the \$100,000 limit on administrative costs of an infrastructure project and leave the 10% of the overall project cost limit.

Recommendation 32.2: Revise language in the proposed rule that appears to limit administrative expenses to employees.”

### **33. Maintenance Costs**

The Commission proposes limiting the support for maintenance costs to:

- Up to 85% of the reasonable, necessary and customary ongoing maintenance costs for networks funded by the health infrastructure program.
- A defined period of time such as 3 years from completion of build-out, or 5 years from the first FCL (whichever period is shorter).

Comment: We applaud the Commission for recognizing the need to support the maintenance of projects during their early years. Infrastructure build-out and connectivity will occur on an ongoing basis. Over time the ratio of maintenance cost to number of users should gradually decrease while sources of revenue increase. The actual deployment of infrastructure may be slowest in rural areas, and supporting these projects in the early stages is critical.

Recommendation 33.1: Change the phrase “whichever period is shorter” to read, “whichever period is longer.”

### **34. Internet2 and NLR**

The Commission proposes that:

- Participants may receive support for not more than 85 percent of the membership fees for connecting their networks to the dedicated nationwide backbones, Internet2 or NLR. Other recurring costs related to connecting to such backbone networks are not allowed.

Comment: Internet2, NLR, and U.S. UCAN provide research and education network backbones that can also serve health care institutions. Research, education, and health care organizations often focus on common issues with the aim of promoting the public good. Thus, it is not surprising to see that ONC is funding initiatives that span research and health care (e.g. SHARP and the Beacon Communities) and initiatives that span education and health care (e.g. the HIT Regional Extension Centers). Rural health care providers would especially benefit by having reliable access to organizations actively involved in all three of the domains of research, education and health. Non-profit R&E network backbones are specifically designed to provide optimal nationwide access to such organizations, including Cancer Centers, Academic Medical Centers, Children’s Research Hospitals, and VA Medical Centers. These advanced backbones are uniquely capable of reliably supporting demanding HD videoconferencing and large dataset transport by providing infrastructure with minimal or no packet loss and little or no congestion.

Recommendation 35.1: Adopt the rule and clarify in the rule that the fee to participate in the nonprofit network backbones is a recurring annual fee.

### 36. Ineligible costs

Comment: It is critical that an eligible services matrix be developed and that a right of waiver or appeal process be developed. The current process of proposing services for USAC consideration has led to serious delays and conflicting responses.

Ineligible costs represent a serious risk to any project. The single most important factor in the success of a project is to make sure that all costs are covered. Therefore, it is critical to have a final and complete determination of the eligible costs before the network construction begins.

Specific service comments:

- Help Desk
  - Helpdesk facilities typically mean the support of services and applications available from a data center. We agree that these services are not eligible for support.
  - However, Network Operations Centers, including their help desk services, are a critical component of network maintenance and therefore should be an eligible cost.
- Continuous Power

- Conditioned and continuous power is a critical resource for reliable networks and should be eligible expenses. Poor quality power causes network equipment failures and the loss of network service. Lightning, accidents, and general circuit overloads bring down electrical distribution systems regularly. Without UPSs and other forms of battery backup, networks would be down with regularity. Designers attempt to bring power feeds to large data centers and network nodes from more than one substation and preferably from more than one power plant.
- Billing costs
  - Meeting the billing needs of a consortium is an operational cost. The HIP and the HBSP have a goal to create regional, statewide and national health care networks, and that requires consortium arrangements and their operational costs should be eligible expenses.

The Commission should encourage and incentivize awardees to connect to state level health information exchanges being built from funding through the Office of the National Coordinator for Health IT. All health care providers will ultimately need to be connected through network services. While the Rural Health Program cannot subsidize the construction of a network to connect for-profit health care providers, it should be made clear that we need to create seamless connectivity among all health care providers. To this end the Rural Health Program should incentivize its networks to connect to the state level networks being built with ONC funding.

Recommendation: Eligible costs within a project should be a part of the Form 465 (or its successor) evaluation by THE COMMISSION/USAC. The eligible costs should include activities and services necessary for the operation of the network including appropriate Help Desk, Continuous Power, and Billing expenses.

Recommendation: Connections to other health networks such as Health Information Exchanges is encouraged and should be mandatory.

### **38. Minimum Participant Contribution**

Comment: Construction projects usually spend a lot of money in a short time but recoup the benefit over a long time. So, requiring more than a 15% contribution up front from those who may benefit over 10, 15, or 20 years would often be difficult. The RHCPP experience has shown that many overcame this hardship but others suffered long delays and in some cases placed projects into limbo. The 15% match is a good and acceptable burden that ensures commitment of the participants. It is also recommended that the Commission establish a strict but accomplishable waiver process.

In-kind contributions should be allowed. This is consistent with other federal programs aimed at developing the health information exchange such as CMS and ONC. The use of in-kind matching would allow administrative efforts to contribute to the overall project and reduce the burden of raising the 15% capital match.

#### **40. Evidence of Viable Source for 15 Percent Contribution**

Comment: The evidence of the ability to pay the required 15% is reasonable. However, separate evidence of this ability should be allowed at the participant's discretion (a) for the project as a whole or (b) separately for design stage and the build stage of a project. The design stage is significantly less costly, comes earlier and lays the groundwork for the cost basis of the build project. In some projects it is only reasonable to ask for the evidence of the 15% for the build phase of a project once all of these factors and costs are known.

Ninety (90) days is too short a time to secure a state or federal grant. Timeline should be extended to 180 days to provide enough time to secure matching funds. In-kind match should also be allowed. Revenue from connecting ineligible for-profit providers should also be allowed as part of the 15% match.

#### **41. Eligible Sources**

Recommendation 41.1: Broadband Technology Opportunity Program awards should be eligible sources of funding and 15% match.

#### **42. Project Milestones**

Recommendation 42.1: To align with participants publishing project schedules, USAC should publish clear criteria for each of the steps in the award process at the start of the project. This will eliminate many of the problems facing the first round of RHCPP awardees.

#### **45. Network Coverage**

Recommendation 45.1: Connectivity should be treated as part of an expanding project plan. As state level health information exchanges come into existence, connectivity to these networks will be critical. Yet, they may not exist at the time of the proposal.

#### **47. Health IT Purposes**

Recommendation 47.1: Proposals should address how the proposed HIP program will integrate with state level health information exchanges being built, regional health information organizations and hospital-based networks. The Rural Health Program should require connection to the state level health information exchange if feasible. The HIP should incentivize connection to these health information exchanges to encourage total health care information exchange rather than partial, inefficient exchange.

#### **48. Emergency Response Connectivity**

Comment: A network may be a part of a set of disaster response resources. Such a network may incur costs of being disaster-proof for those not involved in disaster response (though plenty of eligible entities are part of disaster response.) If this is a part of the role of a particular network, the proposal should identify the role and describe how the network will help. The additional costs required because of the disaster response role should be eligible for the 85% subsidy.

#### **49. Facilities ownership, IRU or Capital Lease Requirements**

Comment: The prohibition of entering into "short term" lease agreements for managed services is not acceptable as written. In at least one instance from the RHCPP, "Short Term" is actually 10 years, a length of time encouraged by the Commission. The demands of health care are such that it is appropriate to meet that demand from the most appropriate sector including the private sector. By aggregating the demand of the health care sector in Colorado, the statewide network has caused substantial private sector investment (est. \$20M), leveraging the Commission's support by over 2-to-1. Deploying the statewide network through a leased services agreement with a competitive vendor has led to increased bandwidth availability at reduced cost in rural areas.

#### **59. Sustainability Reporting Requirement**

Comment: Sources of Future Support should not be based on commitments by individual entities. For a Consortia-based project, the support should describe the rationale for the later commitment of entities of the type being served rather than show that specific entities are already (even before design) committed and will have funds for the life of the network (20+ years).

#### **61. Shared Use**

Comment: As noted in the National Broadband Plan, broadband networks are community resources that have significant social and economic benefits. Accordingly, building a network infrastructure that serves a single purpose, such as health care, is shortsighted and not an optimal use of the limited resources available to construct these facilities. The Rural Health Program is restricted to providing funding for resources that meet the specific needs of health care. However, a community that has the resources to fund the incremental costs of additional bandwidth or fiber in order to meet other needs of the community should be encouraged.

The FCC Rural Health Infrastructure Program includes the initial cost of developing a network that meets the specific health care needs of the eligible institutions. Additional facilities such as excess bandwidth or additional fibers should be permissible as long as no FCC funds are used for these resources. The full incremental costs should be paid for the additional resources.

In situations where multiple services use the same shared plant, and it is necessary to distribute cost, the model developed by the Michigan Public Health Institute is recommended as a means of allocation of costs. While this was developed for data centers it has more general applicability. This process uses the volume of data and the subsidy rate. (Attachment 2)

Recommendation 61.1: Allow/encourage the use the MPHI model as a basis for allocating costs for shared resources.

### III. Health Broadband Services Program

#### 84. Health Broadband Services Program

- Description— replaces the Internet Access Program, expands the definition of funded services, increases the subsidy to 50% (from 25%), and simplifies the application process
- Process --- pays 50% of recurring monthly costs for ANY advanced telecommunications and information service that provide point-to-point broadband connectivity, including dedicated internet access
- Eligible Services

Recommendation: Consortia of health care providers should be eligible to participate in the Health Broadband Service Program.

#### 87. Eligible Access and Transport Services

- The Commission proposes to replace the existing Internet access program with a new health broadband services program, which will subsidize 50 percent of an eligible rural health care provider's recurring monthly costs for any advanced telecommunications and information services that provide **point-to-point** broadband connectivity, including Dedicated Internet Access.

Comment: This term "point-to-point" is often used to refer to a connection that is restricted to two endpoints and with no data or packet formatting. While some connections may have to use older technology with this limitation, it should not be encouraged, much less required. Health care organizations seeking modern, cost-effective telecommunication services should aim to employ an IP network, whether it is the public Internet or a dedicated health network. This approach has been consistently adopted by ONC and the NHIN workgroups.

Recommendation 87.1: Delete the term "point-to-point."

#### 90. Access to advanced telecommunications and information services

Comment: This paragraph states that the HBSP will "...support the recurring costs of access to advanced telecommunications and information services... ". Some service providers, particularly Regional Networks, bill annually rather than monthly. We wish to clarify that these recurring annual costs are included in the

HBSP.

Comment: Health Care Provider sites should not be limited to rural to be eligible for discounts under the HBSP. For example, in North Carolina about 50% of the health care providers are at rural sites, but many non-rural sites serve rural populations and non-rural sites also serve vulnerable populations. These populations frequently have no affordable broadband facilities adequate to support the next generation of typical uses. In addition, tertiary facilities in metro areas often provide critical specialty services to rural populations.

Recommendation: Eligible services include health care providers serving rural and underserved populations irrespective of their geographic location.

Comment: The Commission needs to clarify that eligible uses are much wider than individual human health care and include public health, medical-education, health related research (including clinical trials), and patient education.

## 91. Minimum Level of Broadband Capability

The commission seeks comment on:

- What should be the minimum level of reliability, including physical redundancy, to support health IT services and what can be done to encourage reliability?
- What minimum quality of service requirements should be required to meet health IT needs?

Comment: Health applications need to perform well and consistently. The approach favored by R&E networks is to over-provision the network to make sure there is enough capacity to accommodate most or all of the network peak loads. An alternative approach to ensuring good performance is to employ differentiated service levels using QoS, an approach that can be difficult to deploy.

Reliability factors such as 99.9% (as recommended in the Health Care Broadband in America<sup>3</sup>) means nearly nine hours of outage per year, or 45 minutes a month.

Comment: Two problems that can degrade health care applications are packet loss and VPN restrictions. Even 1% packet loss can make large dataset transport fail or take an unacceptably long time. The packet loss for a health network should be less than .01%.

VPNs typically restrict traffic to point-to-point connections, an approach that does not scale to allow one health care provider to connect to any other health care provider.

Mobile Health (mHealth) was addressed in the National Broadband Plan as

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<sup>3</sup> Health care Broadband in America: Early analysis and a path forward, FCC OBI Technical Paper No. 5, August 2010

important new use of technology for health care. It is our understanding that the proposed Rural Health Care Program is technology neutral, it is important enough that the Commission should be explicit in its eligibility for support.

Recommendation 91.1: Identify mobile/wireless broadband technologies used to provide health care services to rural communities as eligible for support within the Rural Health Program.

Recommendation 91.2: The bandwidth requirements for mHealth infrastructure be different than those for land based networks.

## **97. Restrictions on Satellite Services**

Recommendation 97.1: Suggest that satellite services used to support

## **100. Level of Support**

Comment: The National Broadband Plan recommended that the Commission base discount levels for the health broadband services program on criteria that address such factors as lack of broadband access, lack of affordable broadband, price discrepancies for similar broadband services between health care providers, the health care provider's inability to afford broadband services, special status for health care providers in the highest Health Professional Shortage Areas (HPSAs) of the country, and special status for public or safety net institutions.

The Commission notes that there is a "dearth of available information" to support processes for making decisions about levels of support. In at least Colorado, there are significant core infrastructure costs associated with a private health care broadband network, both for non-recurring (NRC) and monthly recurring (MRC) costs. For the Colorado Telehealth Network, this amount is \$6,773/site for NRC and \$502/mo for MRC (\$6,240/yr).

Core infrastructure here means equipment and circuits necessary to support the basic telecommunications function of private network with the service level architecture needed to support health care, including: inter-carrier interconnects, LATA boundary interconnects, transport layer interconnects (Metropolitan Ethernet to ATM), core network hardware for IP number aggregation, firewall, quality of service, multi-casting and maintenance, primary and back-up commodity Internet access, and Internet2 access. These costs are unique to a health-care quality network compared to routine commodity Internet access and represent a barrier to entry for health care providers to participate in a regional or statewide private health care network.

Recommendation 100.1: Verified core infrastructure costs (shared infrastructure needed to form a network), should be subsidized at 85% for both non-recurring and monthly recurring charges.

Recommendation 100.2: Non-recurring costs (e.g. installation) are a serious barrier to participation of rural Health Care Providers. Given the goal of the Health Broadband Services Program to increase rural health care broadband connectivity, the non-recurring cost barrier should be minimized. We suggest that the non-recurring cost be treated the same as infrastructure and be eligible for an 85% subsidy.

### **105.-106. Multi Year Contracts**

Comment: The "evergreen" status should apply to existing Pilot Projects with evergreen contracts; and the Pilot Project should be able to post Form 466-A on behalf of its existing Participating HCPs (PHCPs) for HBSP support; those existing PHCPs should not need to apply individually for HBSP support, and as long as the contract is evergreen, the Pilot Project should be able to add new, eligible PHCPs, and those would receive HBSP support.

### **107. Opting into the Health Broadband Services Program**

Comment: Pilot Program participants should be allowed to transition to the Health Broadband Services Program as long as the Pilot Program contract is evergreen. "Participants" should include the consortia organizations created on behalf of all of their participating Health Care Providers.

This should also mean that sites on 465 for a pilot project that have not made use of discounts under the pilot should be immediately eligible for discounts under the HBSP.

### **108. – 111. Administrative Offices**

Comment: The experience of the Rural Health Pilot Program was that the identification of eligible facilities led to inconsistent judgments and extensive delays. We strongly endorse the approach of the Michigan Public Health Institute by pre-identifying eligible and ineligible facilities. (Addendum 3) While this approach needs to be updated for the new rural health program, the clear identification of eligible facilities is critical to the success of the program.

We endorse the support for administrative offices. According to the NPRM, Administrative Offices have to be owned or controlled by an eligible provider. We understand a "controlled" office to mean an administrative office that is directly controlled or is an outsourced resource meeting the needs of the eligible providers or their consortium. Administrative offices should include those offices that manage and maintain the health care network infrastructure as well as administer to the health care activities of patients, regardless of where these offices reside.

Many health care organizations have moved their administrative operations into separate facilities where patients are not directly seen but should be connected to the locations where patients are being provided services in order for health services to be provided. These administrative hubs are critical for overall

operations of the health care provider organization and should be included in the overall network connectivity. Functions include administrative support, billing, risk management, education and training. For example, in New Mexico health provider organizations have separate administrative facilities and should be considered eligible sites for broadband connectivity. The organizations include University of New Mexico, Presbyterian Health Services, primary Care Association, and Indian Health Services (IHS) area offices.

#### **114. Data Centers**

We endorse the support of data centers. A data center is eligible for FCC funding to the extent the data it transmits and receives falls into eligible health care categories. Data centers include staff dedicated to the operation of the computing and information resources. Data centers necessary to provide and support the delivery of health care should be eligible regardless of their location. Data centers and Network Operation and Management Centers vary in structure and function across different health care networks. A data center could be nothing more than a data drop or closet in a field or facility. For example, a data center may be leased or housed at an ineligible entity because of technical requirements or location.

Health care organizations use data centers that are critical in order to be able to provide health service. The data centers enable information transfer between health care facilities, health information exchanges (HIEs), as well as between health care organization networks. These data centers may serve as information repositories or provide “edge servers” or gateways that allow access to individual patient data accessible through a master person index (MPI), data mining and business associate agreements, e.g. laboratory services.

For example, New Mexico has a HIE and data center that serves several stakeholder health care organizations. Currently New Mexico has over 1.3 million unique patients enrolled in this MPI network. Individual health care provider organizations in this region also have data centers supporting their operations within the state and even at major national centers in other states, such as the New Mexico Primary Care Association. These centers need broadband connectivity to enable effective operations. In order for the Commission supported broadband initiatives to achieve the goal of enhancing telemedicine networks, these data centers should be included as eligible sites within the networks of networks.

Support of the communications facilities to the data center that meet the needs of the health services should be determined or allocated by any reasonable method. No single method for the determination of this allocation is likely to be applicable to all data centers. We suggest changing all of the provisions concerning percentage of centers to a model in which the only eligible uses at a site data center functions are the ones supporting Health Care Provide eligible functions – regardless of site ownership or control percentage (e.g. a dedicated

link from a data center to (only) a network of eligible users should be fully discountable).

In situations where multiple services use the same shared plant, and it is necessary to distribute cost, the model developed by the Michigan Public Health Institute is recommended as a means of allocation of costs. While this was developed for data centers it has more general applicability.

“Generally, a data center is eligible for FCC funding to the extent the data it transmits and receives falls into eligible health care categories, as defined in Attachment 1 (now Addendum 2) to this letter. For example, let’s say that Hospital System X’s Data Center will use its 1 GBPS, FCC-funded fiber connection to the FCC-funded network to move data to and from all of X’s 40+ sites. To perform our calculation, let’s use July 2010 data. Let’s assume X knows the volume of data transmitted to and from each of the 40+ sites during July. Let’s further assume that X, with Michigan Public Health Institute’s help, can use Attachment 1 (now Addendum 2) to quickly categorize each of its 40+ sites as either eligible or ineligible. Now, let’s multiply each site’s volume of data by its eligibility percentage, and then let’s add all of the sites’ multiplication products together. Let’s assume that the sum of the 40+ sites’ products is 10.4 GB, and that the total volume of data for all 40+ sites is 11.1 GB. That means that the Data Center would be 10.4/11.1 eligible, or 93.7 percent eligible.”

### **117. Skilled Nursing Facilities**

NPRM states that to be eligible one of the following conditions needs to be met:

- Certificate of Need for 51% of beds as a SNF or
- 51% of revenue for past year is from SNF services?

Comment: We do not follow the logic of tying HBSP support to Medicare-eligible sites. Custodial nursing services are an integral and important component of the nation's health care service infrastructure and we believe it is therefore consistent with the goals of the HBSP to include these as eligible entities.

### **121. Annual Caps and Prioritization Rules**

Comment: We disagree with the concepts of caps for the programs. We agree that targets should be established and the proposed budget caps would be reasonable as targets. The Commission/USAC administrators should have the flexibility of making any unclaimed amounts under one program target available to add to the other program.

Language suggests that when the cap is reached funding to the existing programs (for rural-urban equity) will be reduced. This could potentially affect all of the rural health centers that are mainly dependent on this existing subsidy for telecommunications services. Any cap should apply to future additions rather than take away from rural health centers that are currently utilizing the programs.

The NPRM language appears to suggest that when the cap is reached the funding to the existing programs (for rural-urban equity) will be reduced. This could affect all of the rural health centers dependent on this subsidy for telecommunications services.

Recommendation 121.1: Remove the concept of ‘caps’ from the Rural Health Program and replace with budget targets and retain the flexibility of moving excess funds from one program into another program with more demand.

Recommendation 121.2 If a cap or a target is applied, existing program participants should be grandfathered and retain at least their current subsidy level.

## **122. Prioritization Rules**

NPRM requests ideas for selection criteria if the combined requests exceed \$100M for Infrastructure or \$300M for telecom and broadband.

Recommendation 122.1: If and when prioritization is required it should be based on:

- a. Neediness of the population to be served by the proposed network or support program
- b. The size of the population being served by the proposed program
- c. Support for other public policy priorities (e.g. meaningful use)
- d. The ability of the proposer to execute the proposed program

## **134. Meaningful Use Criteria**

Comment: Meaningful Use will not apply to all health care providers eligible for the Rural Health Program. A 10% Medicaid volume is required under Meaningful Use, and, at least in Florida, not all rural, eligible, non-profit hospitals can demonstrate that volume. The RHCPP should not discriminate among providers based on Meaningful Use. Adding an incentive by increasing discounts or using other mechanisms to incentivize providers to reach Meaningful Use would be a positive approach. We recommend that prospective ‘Meaningful Use’ participants get either additional discounts (up to 85%) and/or preference if prioritizing funds needed.

Recommendation 134.1: Participants in the HBSP that qualify for ‘meaningful use’ incentives from HHS earn additional discounts (up to 85%) and/or preference if prioritizing funds needed.

## **139. Health Care Broadband Status Report and Testing Mechanisms**

NPRM proposes setting aside \$5M to fund innovative ideas for evaluating broadband efforts or improve upon them.

Comment: We support the Status Report and Testing Program and suggest that \$5M may be less than sufficient to adequately fund this activity.

**141. Creating a workgroup to develop recommendations**

Comment: We support the formation of a workgroup to provide recommendations about the Rural Health Care Support Mechanism for the Commission. Such a group should include participants from the Rural Health Care Pilot Program.

**Addendum 1**  
**Proposed Letter of Agency**

**Date:**

**To: (Health Care Provider Executive / Authorized Person)**

Re: Letter of Agency for Rural Health Care Pilot Program

By this letter, **[Health Care Provider Name]** confirms its participation in the FCC Rural Health Care Pilot Program project known as the North Carolina Telehealth Network (NCTN). **[Health Care Provider Name]** hereby authorizes Cabarrus Health Alliance (CHA) to act, as an agent, on its behalf before the Federal Communications Commission (FCC) in matters related to the Rural Health Care Pilot Program, unless the agency has terminated this agreement through written notice before construction of telecommunications services or telecommunications services are started. **[Health Care Provider Name]** is a participant in the NCTN Rural Health Care Pilot Program. **[Health Care Provider Name]** authorizes Cabarrus Health Alliance to submit FCC Form 465, FCC Form 466-A, FCC Form 467 and any other Rural Health Care Pilot Program forms and attachments to the Rural Health Care Division of the Universal Service Administrative Company on behalf of **[Health Care Provider Name]**. This Letter of Agency is effective from the date of this letter to the network build-out deadline as defined by the FCC.<sup>1</sup>

**[Health Care Provider Name]** understands that membership in the NCTN does not obligate the Health Care Provider to any costs. Rather, this signed Letter of Agency only enables the NCTN, as directed by the CHA, to include **[Health Care Provider Name]** in bids for services that **[Health Care Provider Name]** may later elect to purchase or not to purchase. The CHA will issue and evaluate open competitive bids to which **[Health Care Provider Name]** shall have full access. In addition, the Letter of Agency enables the CHA to apply funding from the RHCPP to subsidize a substantial portion of the costs for eligible services.

**[Health Care Provider Name]** understands and agrees that, with the permission of the FCC, the NC Association of Local Health Directors, the NC Association of Free Clinics, and the Cabarrus Health Alliance, the authorization provided to Cabarrus Health Alliance in this letter of agency may be passed to another party named the North Carolina Telehealth Network Association.

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<sup>1</sup> See *In the Matter of Rural Health Care Support Mechanism*, WC Docket 02-60, Order, 22 FCC Rcd 20360, ¶¶ 35, 94 (2007) (defining the network build-out deadline as five years from the Pilot Program Participant's receipt of the initial Funding Commitment Letter.).

By this Letter of Agency, **[Health Care Provider Name]** authorizes Cabarrus Health Alliance to make the certifications included in the FCC Forms 465, 466-A and 467 on behalf of **[Health Care Provider Name]**. In addition to the certifications contained in the above referenced FCC Forms, **[Health Care Provider Name]** certifies to the following:

- a) **[Health Care Provider Name]** certifies that it is a non-profit or public entity.
- b) **[Health Care Provider Name]** certifies that it has followed any applicable State or local procurement rules.
- c) **[Health Care Provider Name]** certifies that telecommunications services and network capacity provided to it as a result of its participation in the Pilot Program will be used solely for purposes reasonably related to the provision of health care service or instruction that it is legally authorized to provide under the law of the state in which the services are provided and will not be sold, resold, or transferred in consideration for money or any other thing of value.
- d) **[Health Care Provider Name]** certifies that it will retain documentation of its purchases of telecommunications service related to the Pilot Program for five years from the end of the funding year.
- e) **[Health Care Provider Name]** acknowledges that FCC rules provide that individual health care facilities participating in the Pilot Program that have been convicted of a felony, indicted, suspended, or debarred from award of federal or state contracts or are not in compliance with the FCC's rules and regulations, are not be eligible for discounts under the Pilot Program.
- f) **[Health Care Provider Name]** certifies that, to the best of its knowledge, the non-discount portion of the costs for eligible services will not be paid by the telecommunications service provider.
- g) **[Health Care Provider Name]** acknowledges that the provision, by the telecommunications service provider of a supported service, of free services or products unrelated to the supported service or product constitutes a rebate of some or all of the cost of the supported services.
- h) **[Health Care Provider Name]** certifies that **[name of person authorized to sign LOA]** is authorized to sign this Letter of Agency and is authorized to act on behalf of **[Health Care Provider Name]** in matters related to the Pilot Program. **[Authorized Person]**'s contact information is provided below.
- i) **[Health Care Provider Name]** acknowledges that it shall be subject to audit by the FCC and, if necessary, investigated by the FCC, to determine compliance with the Pilot Program, FCC rules and orders as well as section 254 of the Communications Act of 1934, as amended.

[Health Care Provider Name], is a non-profit health care provider in the State of North Carolina and is a participant in the NCTN's Rural Health Care Pilot Program.

For each site that this letter of agency covers, provide the information below:

- County of Site:**
- NCTN Site Identifier:**
- Health Site Name:**
- Site Street Address:**
- Site City, State, ZIP:**
- Site Phone number:**
- Is this data a correction to the data in the site list? (Yes, No, New Site)**

{Repeat the items above as needed if there are additional sites}

All sites that [Health Care Provider Name] wishes to be included in the NCTN are listed above.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**Name**

**Title of Authorized Person**

**Address**

**Phone Number**

**Fax Number**

**Email Address**

## Addendum 2

### MPHI Data Center Eligibility Percentage

Generally, a data center is eligible for FCC funding to the extent the data it transmits and receives falls into eligible health care categories, as defined in Attachment 1 (now Addendum 3) to this letter. For example, let's say that Hospital System X's Data Center will use its 1 GBPS, FCC-funded fiber connection to the FCC-funded network to move data to and from all of X's 40+ sites. To perform our calculation, let's use July 2010 data. Let's assume X knows the volume of data transmitted to and from each of the 40+ sites during July. Let's further assume that X, with MPHI's help, can use Attachment 1 to quickly categorize each of its 40+ sites as either eligible or ineligible. Now, let's multiply each site's volume of data by its eligibility percentage, and then let's add all of the sites' multiplication products together. Let's assume that the sum of the 40+ sites' products is 10.4 GB, and that the total volume of data for all 40+ sites is 11.1 GB. That means that the Data Center would be  $10.4/11.1$  eligible, or 93.7 percent eligible.

A simpler method would be to list all sites with which the data center communicates (presumably 40+ sites), list each site's eligibility percentage, and then calculate the *simple average* of those percentages. While this method is easier, it would not work to X's advantage, as an ineligible nursing home (very low volume of data) would carry the same weight as X's largest hospital (huge volume of data). Weighting each site by using the site's *volume* of data, as the method described in the previous paragraph does, should yield a much higher eligibility percentage than an unweighted average.

## **Addendum 3**

### **Health Care Provider Site Eligibility Rules under the RHCPP Based on MPHI's Experience with USAC Rulings, October 2008 – April 2010**

The Universal Service Administrative Company (USAC) makes official eligibility-ineligibility determinations. However, to ensure that the project is able to submit its Form 466-A package to USAC by the USAC-imposed deadline of June 30, 2011, MPHI will make preliminary eligibility rulings that will carry the same weight as USAC's. Determinations are made by site using the following criteria. A health care provider may have both eligible and ineligible sites.

**Eligible** facilities include:

- Medical hospitals
- Rehab hospitals with licensed hospital beds (note the list of ineligible rehab facilities detailed below)
- Psychiatric hospitals with licensed hospital beds (note the list of ineligible community mental health centers [CMHCs] detailed below)
- Medical clinics
- School-based clinics
- Dental clinics
- Pain centers
- Regional labs
- Radiology facilities
- Facilities offering outpatient physical therapy, physical rehabilitation, or speech therapy provided by one or more licensed health care professionals (e.g., DPTs, LPNs, PTs, and RNs)
- CMHCs offering traditional outpatient mental health counseling, including outpatient substance abuse counseling
- CMHCs offering short-term stabilization of acute mental health conditions
- Public health departments
- Off-site data centers (i.e., data centers that support health care but are located in buildings that do not house clinical operations), but only to the extent that their operations support eligible activities or facilities listed in this document versus ineligible activities or facilities listed in this document (i.e., support must be pro-rated)<sup>2</sup>

**Ineligible** facilities include:

- Any for-profit health care facility
- Off-site administrative offices (i.e., administrative operations that support health care but are located in buildings that do not house clinical operations)
- Assisted living facilities and nursing homes
- Skilled nursing facilities
- Hospices
- Renal dialysis centers
- Facilities providing home health care services, e.g., visiting nurse associations (VNAs)
- In-patient rehab centers (other than rehab hospitals)
- Centers offering outpatient physical therapy or physical rehabilitation not provided by at least one licensed health care professional (e.g., a nurse)
- Fitness centers (exercise, wellness, physical fitness, etc.)
- Emergency medical service facilities (e.g., ambulance services)

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<sup>2</sup> Data centers are ruled eligible or ineligible at the Form 466-A step in the RHCPP process. Pro-rated eligibility can be calculated based on bandwidth usage for eligible and ineligible activities; bandwidth usage by eligible and ineligible facilities served; the number of eligible and ineligible facilities served; the number of devices located at eligible and ineligible facilities; or any other rational, data-supported algorithm.

- Pharmacies
- Facilities that focus on providing oxygen and equipment
- Group homes for the mentally ill or developmentally disabled
- CMHCs that offer residential substance abuse counseling
- CMHCs that have any other residential component (stays of longer than one night), except those offering short-term stabilization of acute mental health conditions
- CMHCs that focus on teaching daily living skills, offer community integration activities, and/or offer community support services
- CMHCs focusing on vocational training and rehabilitation (including classes, coursework, skill building/acquisition, community support services, and community integration activities)
- Facilities that focus on offering outreach and support services to the homeless or formerly homeless (e.g., Shelter Plus Care programs).
- Any other residential, short-term or long-term care facility not explicitly identified as eligible